Ending the Cycle:

Supportive Transitions and Measuring Impact

DOWNTOWN WOMEN'S CENTER

www.DWCweb.org

ABOUT DWC

The Downtown Women's Center (DWC) provides permanent supportive housing and a safe and healthy community fostering dignity, respect, and personal stability, and advocates ending homelessness for women.

Founded in 1978, DWC is the only resource in Los Angeles that is exclusively dedicated to serving the unique needs of homeless and very low-income women in downtown Los Angeles' Skid Row community.

DOWNTOWN WOMEN'S CENTER

www.DWCweb.org

DWC Programs and Services

DWC is nationally recognized as a prototype for unique and effective programs serving homeless women and ending homelessness. DWC served over 4000 women last year.

DAY CENTER

- 200 women visit the drop-in Day Center each day
- Popular services: Meals (over 90,000), Showers, Telephones and Mail

RESIDENCE

- DWC provides 119 units of permanent supportive housing (2 locations)
- 95% of the women we house stay housed permanently—a high success rate for ending homelessness

CLINICAL HEALTH SERVICES

- Case management, mental health services, medical services
- Over 1200 women served

VOCATIONAL EDUCATION AND SOCIAL ENTERPRISE

- Education, skill development and on the job training opportunities
- Over 1200 women served

DWC's CTI Pilot Project

- First application of CTI in Los Angeles started in 2011 at DWC
- Served 80 women in the Skid Row area
- Focused on homeless women moving into permanent housing

- Housed at DWC's PSH, SRO Housing Corporation's PSH, and other permanent housing units

Critical Time Intervention (CTI)

Evidence-Based Practice

Time-limited Case Management

During Times of Transition

CTI Program Elements

Used during times of transition

3 distinct phases with key activities that encourage tenant independence

CTI Program Elements

Practice is time-limited (9 months)

Minimal case load (10-15) with clinical supervision at least once a week

CTI Program Elements

DWC Values

Community

Empowerment

Creativity

Flexibility

Sustainability

Feminism

Compassion

Dignity

DWC Approach to CTI

- Assertive and coordinated case management

- Building community and reducing isolation

DWC Approach to CTI

- Creating a sense of home

- Helping women redefine their identity and create a new way of life

9 Month Model

CTI is carried out in **three distinct phases spanning 9 months** as described below:

Phase	1. Transition	2. Try-Out	3. Transfer of Care
Timing	Months 1-3	Months 4-7	Months 8-9
Purpose	Provide specialized support and implement transition plan	Facilitate and test client's problem-solving skills	Terminate CTI services with support network safely in place
Activities	▪ CTI worker makes home visits ▪ Accompanies clients to community providers ▪ Meets with caregivers ▪ Substitutes for caregivers when necessary ▪ Gives support and advice to client and caregivers ▪ Mediates conflicts between client and caregivers	▪ CTI worker observes operation of support network ▪ Helps to modify network as necessary	▪ CTI worker reaffirms roles of support network members ▪ Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification) ▪ Holds party/meetings to symbolize transfer of care

CTI vs. ICM

Critical Time Intervention (CTI)	Intensive Case Management (ICM)
✓ Provided only during times of transition	✓Can be provided at any time
✓ Case management is time limited with structured Phase (1, 2, 3) transitions	✓Case management can occur for as long as the client needs or program dictates
✓ Sessions are focused and touch on various aspects of stability through a housing lens	✓Sessions can be focused on multiple issues at any time with various milestones
✓ Structured supervisions and sign offs; often, clinical	✓Unstructured supervision
✓ Small caseload	✓ Caseload size may vary

Impact of CTI on Clients and Staff

- How CTI impacts service delivery to clients
- Review of case example

- Rewards and challenges of utilizing CTI in Los Angeles

DWC Metrics

- DWC asked, “How are we making an impact and are we truly ending the cycle of homelessness?”
- Developed a measurement tool with leadership from staff and clients
- Currently piloting the measurement guide with an evaluator

DWC Metrics

- Stability and Ending the Cycle of Homelessness Guide
- Measures across 6 markers of stability
  - Basic Needs, Medical, Mental Health and Substance Abuse, Self Worth, Social Network, Reliable Income
- Adequate vs. Inadequate Housing score
- 5 phases

Stability and Ending the Cycle of Homelessness Measurement Guide

Client Information

Client Name:	**Completed By (HUB):**	☐ **Has Not been Seen**
Assessment Date:	**Reassessment Date:**	**Time Frame:** ☐ T1 ☐ T2 ☐ T3 ☐ T4 ☐ T5 ☐ T6
Client Stability Score:	**Client has:** ☐ Adequate Housing ☐ Inadequate Housing	
Client is in: ☐ Phase 0 ☐ Phase 1 ☐ Phase 2 ☐ Phase 3 ☐ Phase 4	**Client has ended the cycle of homelessness:** ☐ YES ☐ NO	

Stability Index

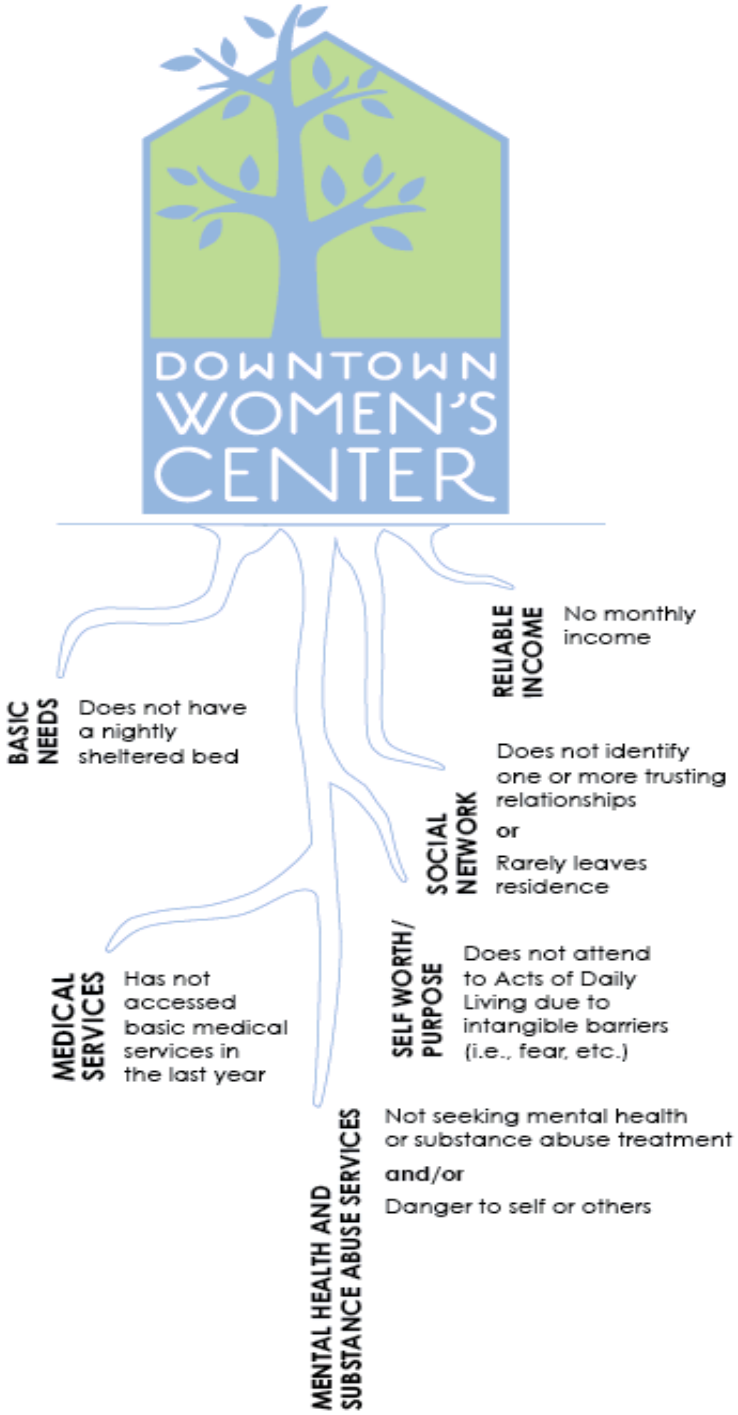
Markers of Stability	Basic Needs **(Marker 1)**	☐ Does not have a nightly sheltered bed and/or meets *one or none* of the following basic needs on a daily basis: ☐ eats an average of 3 meals ☐ showers and grooms herself ☐ wears clean clothing in good condition **1**	☐ Has a nightly sheltered bed (shelter, hotel, apt., etc.) and/or meets *at least 2* of the following basic needs on a daily basis: ☐ eats an average of 3 meals ☐ showers and grooms herself ☐ wears clean clothing in good condition **2**	☐ Has a nightly sheltered bed and meets *the following 3* basic needs on a daily basis: ☐ eats an average of 3 meals ☐ showers and grooms herself ☐ wears clean clothing in good condition **3**	☐ Meets criteria for a score of 3 and ☐ lives in stable housing, such as transitional or temporary housing; has her own bed to sleep in each night **4**	☐ Meets criteria for a score of 4 and does *two* of the following ☐ has the capacity to shower in her own home ☐ prepares or purchases her own meals ☐ purchases and wears her own clothing **5**	Score:
	Medical Services **(Marker 2)**	☐ Has not accessed basic medical services in the last year due to barriers such as ☐ lack of information ☐ fear or lack of motivation ☐ no medical provider ☐ lack of transportation ☐ other **1**	☐ Has accessed medical services once in last year and ☐ Maintains adequate health **2**	☐ Meets criteria for score of 2 in this area and does *at least one* of the following: ☐ Understanding health risks and doing follow up care if needed ☐ In the process of or has secured medical coverage **3**	☐ Meets criteria for score of 3 in this area and does *all* of the following: ☐ Has a medical home and medical coverage ☐ Attends medical appointments ☐ Manages health by following medical treatment plan **4**	☐ Meets criteria for score of 4 in this area and does *all* of the following: ☐ Has medical home and medical coverage ☐ Takes preventative care (i.e. attends health workshops) ☐ Physically active at least twice a week **5**	Score:
	Mental Health and Substance Abuse Services **(Marker 3)**	☐ Not seeking mental health or substance abuse treatment and/or ☐ danger to self or others **1**	☐ Willing to seek mental health or substance abuse treatment (i.e. personally asked for a referral) and ☐ Engagement is inconsistent (i.e. received services, but has not returned) **2**	☐ Connected to mental health treatment and *does all* of the following ☐ Engaged in treatment (i.e. attending treatment on and off) ☐ Learning skills to manage symptoms **3**	☐ Actively participating in mental health or substance abuse treatment (i.e. attending all treatment sessions, rarely misses appointments) and is ☐ Learning and applying skills to manage symptoms **4**	and *does at least 2* of the following ☐ Has the ability to manage symptoms ☐ Able to practice and learn new skills ☐ Adhering to treatment plan **OR** ☐ Has no mental health or substance abuse issues **5**	Score:

	Self Worth/ Purpose **(Marker 4)**	☐ Does not attend to Acts of Daily Living (ADLs) (ex: (showering, dressing, appointment setting), due to intangible barriers such as fear, depression, misconception, lack of motivation, etc. **1**	☐ Attends to ADL's and ☐ inquires about steps to improve daily life but may not take consistent steps towards improving self **2**	☐ Meets criteria for score of 2 and does *at least one* of the following ☐ Identifies activities that bring her pleasure and begins to participate (inconsistently) in activities ☐ Feels sense of role importance **3**	☐ Meets criteria for score of 3 and does *all* of the following ☐ Participates in group or social activity (groups, community events in or outside of DWC) at least 3 times a month ☐ Demonstrates confidence **4**	☐ Meets criteria for score of 4 and *does all* of the following ☐ Starts to set future professional, education, and/or personal goals ☐ Takes steps towards accomplishing goals **5**	Score:
	Social Network **(Marker 5)**	☐ Does not identify 1 or more trusting relationships and/or ☐ Spends time idly in DC or rarely leaves residence **1**	☐ Identifies at least 1 trusting relationship (staff, friend, counselor, and/or family) and ☐ Participates in 1 social activity a month **2**	☐ Meets criteria for score 2 and ☐ Participates in 1 ongoing social activity at least 2 times a month **3**	☐ Meets criteria for score 3 and ☐ Participates in one ongoing social activity at least 3 times a month **4**	☐ Meets criteria for score 4 and ☐ Has taken on a role of a peer leader (i.e. orienting other clients and assisting them in their stabilization) **5**	Score:
	Reliable Income **(Marker 6)**	☐ No monthly income (includes government provided) **1**	☐ Has sporadic income and ☐ Is taking the necessary steps to secure reliable income **2**	☐ Has reliable income from employment or GR (medically unemployable) *If applicable:* ☐ And is in the process of applying for long term benefits (SSI/SSDI) **3**	☐ Meets criteria for score of 3 and ☐ Income is sufficient to meet basic needs such as rent, meals and clothing **4**	☐ Meets criteria for score of 4 and does *all* of the following ☐ Manages finances ☐ Has discretionary income ☐ Can save money each month **5**	Score:
						TOTAL STABILITY SCORE	

HOUSING SCORE	☐ **Inadequate** for Ending the Cycle of Homelessness	Description: *Experiencing any of the following* ▪ Homeless or no sheltered bed ▪ Living in Emergency Shelters or motels/hotels Threatened with eviction ▪ Transitional, temporary or substandard housing ▪ Current rent or mortgage payment is unaffordable (over 30% of income)
	☐ **Adequate** for Ending the Cycle of Homelessness For how long? ☐ Less than 3 months ☐ 3 months – 1 year ☐ More than 1 year	Description: *Experiencing any of the following* ▪ Safe, adequate, subsidized or unsubsidized permanent housing ▪ Subsidized housing where women pay up to 30% of their income ▪ If the woman is in need of supportive services and cannot live independently, she should either live in housing that offers supportive services and/or she should be receiving supportive services from a case manager. Women who meet these criteria may be those who have moderate to severe mental illness, and/or other mental or physical disabilities. ▪ If a woman does not have these risk factors, housing without supportive services is adequate.
PHASE SCORE	☐ Phase 0 - Participant has ***not begun*** the path to stabilization.	▪ Total points are under 12 or ▪ Scored a 1 on at least one marker; at least one barrier to stabilization still exists
	☐ Phase 1 - Participant has ***begun the path*** to stabilization.	▪ Combined total points of 12 ▪ Minimum of 2 on each marker
	☐ Phase 2 - Participant is ***on the path*** to stabilization.	▪ Combined total points of 13 or above ▪ Minimum of 2 on each marker
	☐ Phase 3 - Participant *has* ***reached self sufficiency.***	▪ Combined total points of 24 or above ▪ Minimum of 4 on each marker
	☐ Phase 4 - Participant has ***ended the cycle of homelessness.***	▪ Combined total points of 13 or higher *with* a minimum of 2 on markers #1-5 ▪ *and* a score of 3 on marker #6 ▪ *and* has Adequate Housing for at least one year OR ▪ Combined total points of 24-30 for markers #1-6 for at least one year ▪ *and* has adequate housing for 3 months

PHASE 0

Participant **has not begun** the path to stabilization



PHASE 1

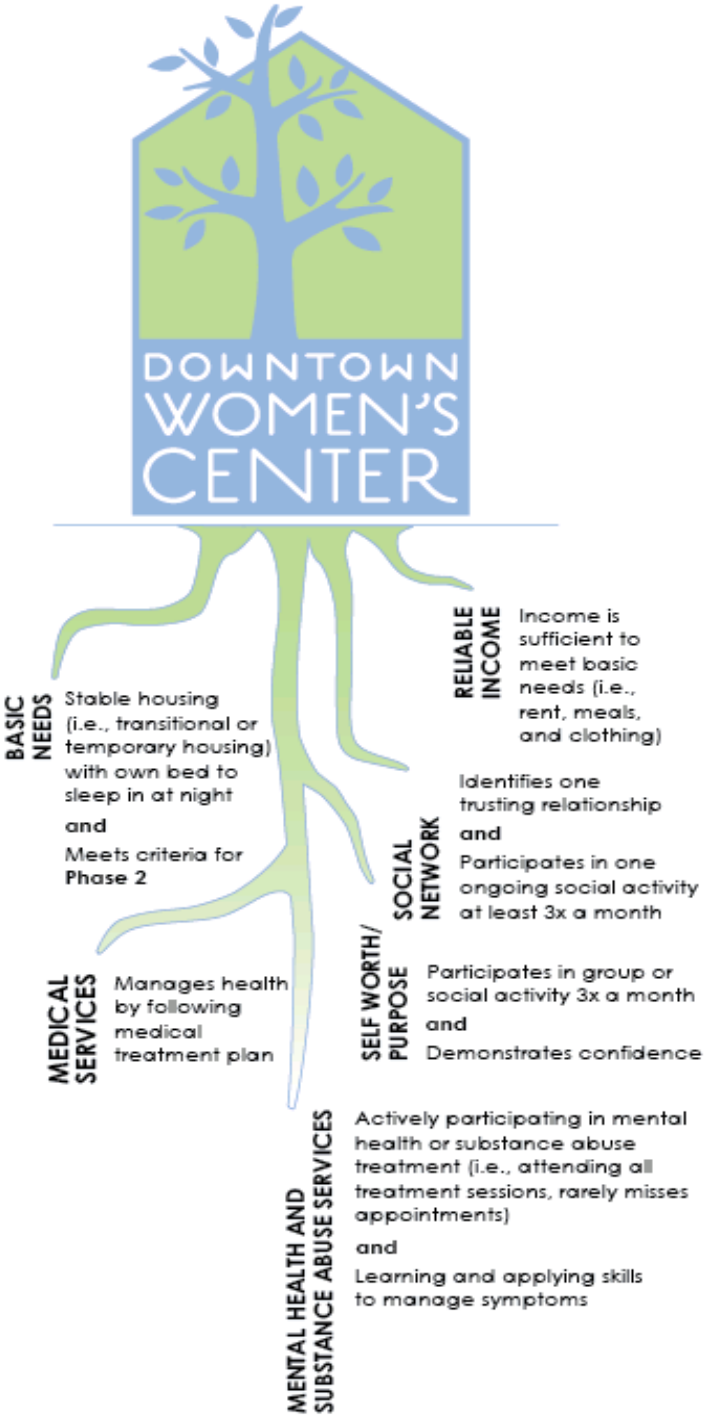
Participant **has begun** the path to stabilization

PHASE 2

Participant **is on the path** to stabilization

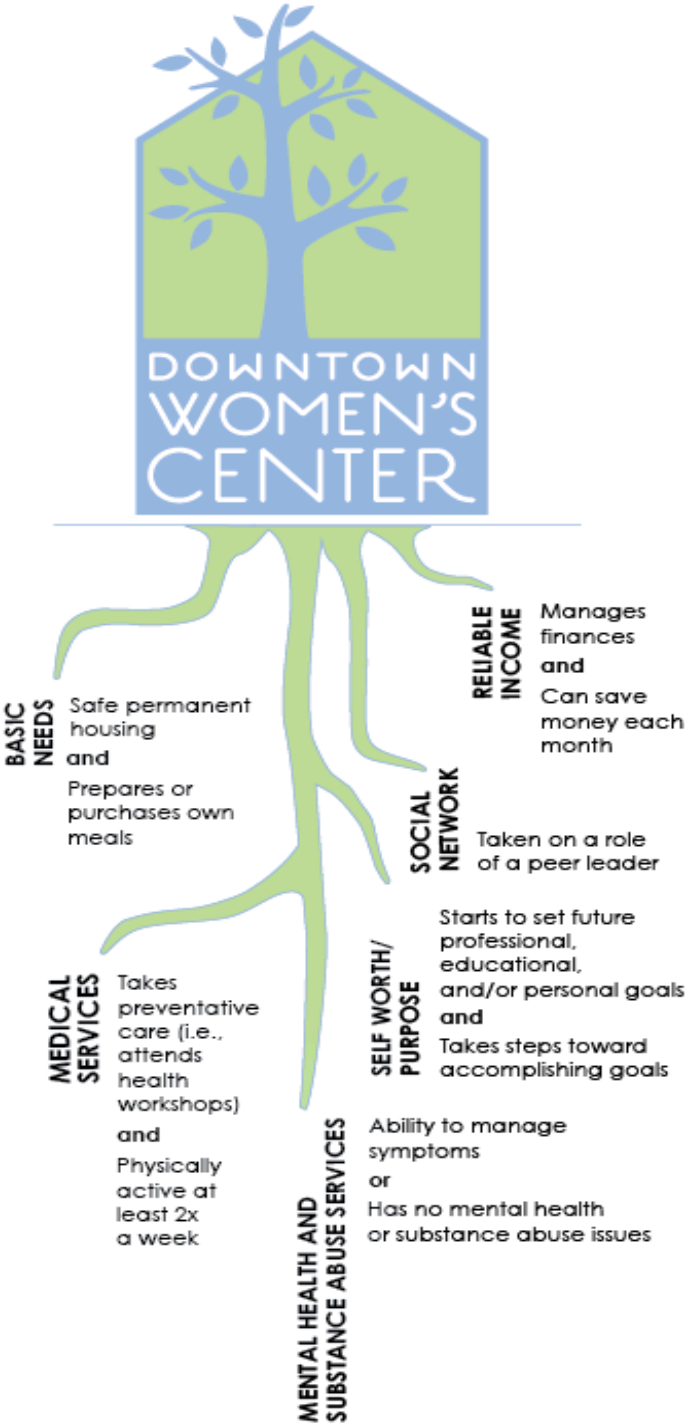
PHASE 3

Participant **has reached** self-sufficiency



PHASE 4

Participant **has ended** the cycle of homelessness



Contact us...

Jenn Ma-Pham
Director of Housing and Clinical Health Services
Downtown Women's Center
JennM@DWCweb.org

Martha Delgado
CTI Program Manager
Downtown Women's Center
MarthaD@DWCweb.org